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ABSTRACT

While self-help groups such as Alcoholics Anonymous are becoming more integrated into the professional substance abuse treatment network, many professionals are still hesitant to encourage clients to attend self-help groups after treatment. This study examined what factors predict the degree of cooperation between professional agencies and self-help groups for substance abusers. Nine agencies in which most of the clients attended self-help groups after treatment were compared to nine agencies in which clients rarely attended self-help groups. The clinical services supervisors of the 18 agencies and staff members (N=247) served as informants. Clients (N=470) admitted to the agencies were interviewed at intake and, at follow-up, they reported on their self-help involvement. The results revealed that the agencies that were well-linked with local self-help groups had larger staffs and employed greater proportions of recovering substance abusers, medical personnel, and paraprofessionals than did the agencies from which few clients participated in self-help groups. The well-linked agencies also were more likely to be in urban areas and to be residential treatment settings. These results suggest that staff and community variables influence the likelihood that clients will attend self-help groups after substance abuse treatment. (Author/NB)

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Substance Abuse Treatment Agencies and Self-Help Groups: Collaborators or Competitors?

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Abstract

While self-help groups such as Alcoholics Anonymous are becoming more integrated into the professional substance abuse treatment network, many professionals are still hesitant to encourage clients to attend self-help groups after treatment. This study examined what factors predict the degree of cooperation between professional agencies and self-help groups for substance abusers. Nine agencies which got most of their clients to attend self-help groups after treatment were compared to nine agencies whose clients rarely attended self-help groups. The agencies that were well-linked with local self-help groups had larger staffs and employed greater proportions of recovering substance abusers, medical personnel, and paraprofessionals than did the agencies that got few clients to participate in self-help. The well-linked agencies were also more likely to be in urban areas and to be residential treatment settings. The results suggest that staff and community variables influence the likelihood that clients will attend self-help groups after substance abuse treatment.

Substance Abuse Treatment Agencies and Self-Help Groups:

Collaborators or Competitors?

Self-help groups for substance abusers, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are increasingly being integrated into the professional substance abuse treatment network as aftercare. However, some professionals remain skeptical about self-help groups and do not encourage their clients to participate in them (Kurtz, 1984), even though there is evidence that participation in self-help groups can help maintain treatment gains after professional support has ended (Emrick, 1987).

It is reasonable to hypothesize that a number of interacting variables affect the extent to which a substance abuse treatment agency cooperates with local self help groups. Guided by the theoretical work of D'Aunno and Price (1985) and our own research findings in this area, we propose that such variables exist at a number of different levels (See Table 1), including the community in which the agency is situated, the physical setting of the agency, the attitudes and behaviors of treatment staff, the characteristics of the clients who are treated at the agency, and the attitudes of persons in the local self-help community. Substance abuse researchers have focused mainly on one level of analysis to explain professional-self help linkages: client variables. Substance abuse treatment agencies are rarely studied, and thus remain a "black box". The effects of the broader community context on the attitudes substance abuse treatment professionals hold towards self-help has also been given little attention.

In the absence of extensive data on agencies and communities, post-treatment participation in AA or NA has been attributed mainly to client characteristics rather than to the ecology of the programs in which the clients were treated, or the communities in which the clients,

agencies, and self-help groups are located. While client factors clearly influence post-treatment self-help group attendance (Humphreys, Mavis, & Stoffelmayr, 1991), recent data suggest that professionals exert considerable influence over the decision of which clients are referred to self-help groups (DenHartog, Homer & Wilson, 1986), and whether or not self-help groups will thrive in the community (Zimmerman et al., 1991).

This study is intended to identify factors which differentiate programs that do not utilize self-help groups as a supportive resource for their clients from those that have a synergistic relationship with substance abuse self-help groups. Unlike most studies of professional-self-help linkages, this investigation will focus on agency and community variables. As the literature offers few guideposts, an exploratory approach was adopted; a small number of agencies was intensively studied to describe how the philosophy, attitudes, beliefs and behaviors of an agency's staff interact with the program's success in getting clients involved in self-help after treatment.

Method

Sample

Treatment Agencies

Eighteen randomly selected substance abuse treatment agencies in the state of Michigan participated in this investigation. Seven of the agencies were residential and eleven were outpatient. All were supported by public funds. Eight of the agencies were located in Detroit, a industrial city in southeast Michigan with a population of one million people. The remainder of the agencies were scattered across smaller cities and towns throughout central and western Michigan. Five of the seven residential agencies were in Detroit, while eight of the eleven outpatient clinics were in central or western Michigan.

Treatment Staff

The clinical services supervisor of each agency (n=18) and staff members (n=247) served as informants. Both clinical and non-clinical staff members participated.

Clients

Clients admitted to the agencies (n=470) were interviewed at intake. At follow-up they reported on their self-help involvement, if any (See Humphreys et al., 1991, for a full description). Client data were used in the study solely for determining an agency's overall success at getting clients to go to self-help groups after treatment.

Procedure

Assessment of Agency's Link with Self-Help

All clients admitted to the agencies being studied were already being followed over time as part of an ongoing treatment outcome study (See Stoffelmayr et al., 1989 for a full description). When clients were recontacted by our research team six months after their admission to treatment, they reported whether or not they were attending meetings of AA, NA or both. When at least 15 clients from an agency were located, that agency was added to the sample. Using these client data, the proportion of each agency's clientele that became involved in self-help groups was calculated.

Influence of AA/NA on Treatment

On-site standardized interviews of the clinical services supervisor of each agency were conducted. The interview covered the goals and approach to treatment of the agency . A subsection of the interview dealt with the supervisor's views about the influence of AA/NA materials and philosophy on the agency (e.g., "How often do you read from AA materials in treatment"). This section included five questions (Cronbach's

Alpha=.793), from which an "AA/NA Influence on Treatment" rating was derived, which ranged from 1 to 5 (Higher scores represent more influence of AA/NA on treatment).

AA/NA Beliefs of Staff

The agency's general level of endorsement of AA/NA principles was assessed by giving every staff member in the agency a checklist of 16 AA/NA beliefs about substance abuse (e.g., "alcoholism is an incurable, progressive disorder"). A score from 1-16 was derived based on the number of beliefs accepted, and then the mean score for all program staff was used to produce a "AA/NA Beliefs" score for each agency (Cronbach's alpha = .88).

Additional Staff Characteristics

Each staff member also reported on whether they were professionals or paraprofessionals and whether or not they were "in recovery" from alcoholism or drug addiction themselves. The total number of staff members at the agency (in Full Time Equivalents) and the proportion of the staff with a medical background (e.g., MD's, RN's) was determined by looking at the agency's application for licensure.

Results

Table 2 presents a correlation matrix of all the continuous variables. Of note are the correlations between the proportion of an agency's clients involved in self-help after treatment and the percentage of staff who are in recovery (r = .44, p = .068), have medical training (r = .52, p < .05), or are paraprofessionals (r = .63, p < .01). There appears to be no linear relationship between a staff's expressed AA/NA beliefs or the influence of AA/NA on treatment and the agency's success at getting clients into posttreatment self-help groups.

The correlations in Table 2 may be somewhat suppressed because the

distribution of the proportion of clients going to self-help was bimodal. Half of the eighteen programs were strongly linked to the self-help community, with most of their clients (M = 72.7%, SD = 10.9%) participating in self-help groups after treatment. In contrast, the other nine programs showed no such relationship with self-help groups; few of their clients (M= 24.2% SD= 9.0%) participated in self-help groups after treatment.

The nine substance abuse agencies that were poorly linked with self-help are compared with the nine well-linked programs in Table 3. The well-linked programs had larger staffs (35.6 FTEs vs. 12.4, $p = .112$), greater proportions of recovering staff (29.9% vs. 12.9%, $p = .07$), greater proportions of medical personnel (17.2% vs. 1.6%, $p < .05$), and greater proportions of paraprofessionals (12.4% vs. 2.0%, $p < .01$). The groups were similar on the staffs' overall level of NA/AA beliefs, and on the clinical supervisor's report of the influence of NA/AA materials and philosophy on treatment.

All nine of the poorly-linked agencies were located in central or western Michigan. All of the agencies in Detroit were well-linked with the self-help community. A related finding concerns the setting of the agency. Six of the 7 residential agencies were well-linked to the self-help community, compared with only 3 of the eleven outpatient agencies $\chi^2(1, N=18) = 5.84$, $p = .016$.

Discussion

Differences between groups must be strong to emerge in small samples, thus it seems reasonable to conclude from the data that agencies that are well-linked with self-help groups can be realistically differentiated from agencies that are not well linked to self-help groups. It appears that variables at different levels are related to such a differentiation. In

this study, agencies in the Detroit area were more likely to be residential and were all well-linked with the self-help community. Detroit has a very high prevalence of substance abuse problems. As both residential agencies and AA/NA are particularly suited to persons with severe substance abuse problems, it makes sense that both would emerge and thrive in Detroit and be able to work together. In contrast, less urbanized areas with less severe substance abuse problems have outpatient clinics and poor ties between professionals and AA/NA. The values of AA/NA and those of professionals who do outpatient therapy for substance abusers clash in many ways (Humphreys, 1991), which may make it difficult for the two camps to maintain strong ties, particularly in communities where the outpatient clinics are more suited to local substance abusing population.

While community context appears to influence professional-self-help cooperation, it also appears that within agency factors have an effect. From the data presented here, it seems reasonable to speculate that agencies with many staff members who are in the recovery movement themselves and/or are paraprofessional have an organizational culture that is supportive of AA and NA. In such an organizational climate (most typically found in residential programs), staff members who are in recovery may serve as powerful role models to substance abusers; they are a testament to the effectiveness of self-help. Similarly, paraprofessional staff may convey to their clients that one does not need to have professional training to help other substance abusers, giving further credibility to the nonprofessional, mutually supportive AA/NA network. Interestingly, the expressed AA/NA beliefs of the staff and the clinical supervisor's evaluation of the influence of AA/NA on treatment did not differentiate between the groups, but the behavior (roles) of the

staff did. It may be that "Do like I do" is a more effective message than "Do what I say". Finally, it is also possible to speculate that medical personnel prime clients to enter AA or NA after treatment because these self-help groups espouse a medical/disease model of substance abuse. Clients who are told by non-medical treatment staff (e.g., social workers, psychologists) that their substance abuse is not a disease may have difficulty accepting the disease model of addiction put forth by the self-help community.

A brief qualitative description of the agencies in the sample that were most and least successful at getting clients into self-help should help concretize the above issues. The agency that got 85% of its clients involved in self-help is a residential program for African-American women which is located in a drug-ridden area of the city of Detroit. The atmosphere of the agency is informal and highly supportive, with a high sense of womanist[1] community. Many of the clients are single mothers who bring their children to the program, giving the agency the atmosphere of an enormous, sometimes chaotic, family. The many former addicts on the staff place strong emphasis on serving as competent role models for the women in the program. No one on the staff has a doctoral degree.

In contrast, the agency that gets only 15% of its clients into self-help is an outpatient clinic located in a small city in Western Michigan. The staff is composed of experienced professionals, the majority of whom have at least one postgraduate degree. The majority of the clients at the agency are white and gainfully employed. The

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[1]The term "womanist" is used by many African-American women to describe their experience and outlook because of the white, middle class connotations of the word "feminist".

atmosphere of the agency is supportive but also rather formalized and task-oriented.

While impressionistic and unstandardized, the qualitative information above hopefully adds some flavor to the quantitative findings of this study. As a whole, the findings of this study shed some light on how agency and community variables affect linkages between substance abuse treatment agencies and self-help groups, although they raise more issues than can be resolved by a single, small investigation. We hope that future investigations of professional- self-help linkages will further illuminate the importance of levels of analysis other than that of the individual client.

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Table 1: Variables that may affect professional-self-help linkages

Community Level
Severity and visibility of substance abuse problems
Stigma attached to substance abuse and treatment
Public funds available for substance abuse treatment
Availability of public transportation

Setting Level Variables
Physical type of agency
Proximity of agencies to local self help groups

Staff variables
Historical cooperation vs. rivalry of agency with self-help groups
Attitudes of director of agency
Number of staff who go to self-help groups
Degree to which agency is professionalized

Self-help variables
Attitudes toward local agency
Attitudes toward professionals in general
Accessibility of self-help group

Client Variables
Problem severity
Attitudes about substance abuse
Experiences with professionals and self-helpers
Gender
Race

Table 2: Correlation Matrix for Continuous Variables

	PSH	BEL	REC	PAR	INF	STA	MED
PSH	1.0						
BEL	.12	1.0					
REC	.44*	-.04	1.0				
PAR	.63***	.15	-.07	1.0			
INF	-.05	.55**	.28	-.30	1.0		
STA	.31	-.02	.21	.16	.01	1.0	
MED	.52**	-.14	.35	.42*	-.23	.18	1.0

Note: *p < .1 **p < .05 ***p < .01

PSH = Proportion of Agency's clients that go on to self-help groups
BEL = AA/NA Beliefs of Staff
REC = Proportion of staff in recovery from substance abuse
PAR = Proportion of staff who are paraprofessionals
INF = Clinical Services Supervisor AA/NA treatment influence score
STA = Staff size
MED = proportion of staff with medical degrees

Table 3: Comparison of Means for Well-Linked and Poorly-Linked Agencies

Staff/Agency Variable	Well-Linked Agencies (n=9)	Poorly-Linked Agencies (n=9)	t(16)	p
Proportion of Clients in Self-Help	72.7%	24.2%	10.24	.000
Staff Size (in FTEs)	35.6	12.4	1.68	.112
AA/NA Influence on Treatment	3.5	3.6	-.22	.828
AA/NA Beliefs of Agency Staff	11.6	11.1	0.71	.487
%Recovering	29.9	12.9	1.94	.070
%Paraprofessional	12.4	2.0	3.37	.004
%Medical	17.3	1.6	2.35	.032